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Nos. 93-1408, 93-1414, 93-1415

IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD,

Petitioners,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

(Caption continued on inside front cover)

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

REPLY BRIEF FOR PETITIONERS NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS AND EMPIRE BLUE CROSS AND BLUE SHIELD

ROBERT A. BICKS
Counsel of Record
PATRICIA ANNE KUHN
ANTHONY C. KAYE
WHITMAN BREED ABBOTT & MORGAN
Attorneys for Empire Blue Cross and Blue Shield
200 Park Avenue
New York, New York 10166
(212) 351-3000

ALAN C. DREWSEN
Senior Vice President and General Counsel
JEFFREY D. CHANSLER
Vice President and Associate General Counsel
EMPIRE BLUE CROSS AND BLUE SHIELD
622 Third Avenue
New York, New York 10017
(212) 476-3200

BARTLEY J. COSTELLO, III
EILEEN M. CONSIDINE
BEVERLY COHEN
HINMAN, STRAUB, PIGORS & MANNING, P.C.
Attorneys for New York State Conference of Blue Cross & Blue Shield Plans
121 State Street
Albany, New York 12207
(518) 436-0751

MARIO M. CUOMO, ET AL.,

Petitioners,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioner,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,

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Preliminary Statement

With the principal briefs lodged, key matters stand beyond dispute. First, New York's regulatory scheme treats ERISA plans no differently from any other payors for hospital services. ERISA plans are free, as are any other persons, to choose Blue Cross, commercial insurance, HMOs or self-funding to provide benefits. The fact is that the Plans cover a high percentage of the ERISA plans in New York State. In any event, the challenged statutes apply across the board to all payors for hospital services without regard to whether the hospital patient is a participant or beneficiary in an ERISA plan. In short, the regulatory scheme at bar is ERISA neutral.

Second, respondents make much of differences in hospital service payment costs between commercial insurers and the Plans stemming from the differentials. But what counts is—not differences in costs—but differences in premiums, and the record is barren of any evidence of the Plans charging lower premiums than the commercials. Just to the contrary, nowhere challenged is the New York Deputy Superintendent of Insurance's showing that even after the 13% differential was enacted the Plans lost substantial numbers of subscribers because "the better risks mov[ed] to commercial insurers who offer lower premiums." (JA-168.)

Third, respondents agree that even absent state regulation of hospital rates generally, or the differentials in particular, there would be no national uniformity in hospital rates or methods of billing.

Fourth, none dispute that "the Blues insure persons and groups that are, on the whole, older and less healthy, and therefore constitute unacceptably high risks for other insurers [and that m]ost high risk policyholders . . . are insured under the Blues." (JA-58.) And though respondents labor mightily to establish the point, not disputed is that one purpose of the challenged differentials is to help the Plans cover added costs, which they alone bear, of engaging in publicly responsible activities. By helping to defray overall costs, and thus alleviating the need for otherwise required rate increases, the differentials help the Plans retain sufficiently large numbers of good risks in their subscriber base to promote the affordability of premiums.

Summary of Argument

What remains in dispute is (1) whether the means chosen by New York State to achieve its objectives of hospital cost control and insurance regulation impermissibly interfere with the choices ERISA plans must make and thus "relate to" such plans. State statutes that create differences in costs, even differences in costs that may make one route for providing hospital coverage less expensive than another, do not mandate that particular benefits be provided or require ERISA plans to structure or administer their plans in any particular fashion. Thus, they do not create the type of interference necessary to trigger preemption. Nor can the influence of the differentials be viewed, as respondents urge, in a vacuum without considering the variety of other factors in the regulatory scheme that impact cost and choice along with the numerous cost and non-cost factors assessed by ERISA plans in determining how best to provide coverage.[1] In enacting ERISA, Congress

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[1] For example, it is uncontroverted that prior to the statutorily prescribed differential, the Plans' differentials ranged between 25% to 40% as a result of hospital by hospital negotiation. (JA-162, 187.) Indeed, as an affidavit submitted by respondents makes clear, one purpose of establishing a 13% statutory differential was to reduce the dif-

surely did not intend to preempt any and all laws which may to any degree influence the choices ERISA plans make in providing coverage.

Arguing to the contrary, Travelers incorrectly asserts that "[p]etitioners' entire argument rests upon their attempt to manufacture a distinct ERISA preemption standard applicable to 'laws of general applicability.' " (Brief for Respondents The Travelers Insurance Company, *et al.* ("Travelers Br.") at 13.)[2] Here, the Plans argue that not only are the challenged differentials laws of general applicability, but also that they do not dictate or unduly restrict choices regarding the structure or administration of plans. Nor do they interfere with national uniformity of plan administration. After, just like before, New York adopted its insurance regulatory scheme, hospital costs and charges not only varied hospital to hospital, but also state to state. Finally, petitioners simply do not urge the Court to narrow the scope of ERISA preemption; rather, they contend that a finding that the challenged differentials are not preempted is fully consistent with the prior decisions of this Court.

(2) Also in dispute is whether the 13% and 11% differentials regulate insurance. However, by going out of their way to argue that the purpose of the differentials is to influence the choice regarding insurance coverage, respondents and *amici* disable their challenge to petitioners' argument that the laws regulate insurance. Furthermore, Travelers' rigid application of the McCarran-Ferguson Act criteria cannot be squared with the broader language of ERISA's saving clause. And ERISA's deemer clause does not exempt self-insured

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ference in rates paid by charge payors, such as commercial insurers, and the Plans. (JA-275-76, 243-48.)

[2] *See* Brief For Respondents New York State Health Maintenance Organization Conference *et al.* ("HMOs Br.") at 32; Brief for NYSA-ILA Welfare Fund, Local No. 807 Labor-Management Health Fund, *et al.* as *Amici Curiae* in Support of Respondents ("NYSA-ILA Br.") at 5 (similarly misconstruing the petitioners' arguments).

funds from the 13% differential because New York's insurance regulatory scheme does not deem self-funded plans to be insurers.

Argument

I.

THE CHALLENGED STATUTES DO NOT RELATE TO ERISA PLANS

A. The Challenged Differentials Do Not Impermissibly Interfere with the Choices ERISA Plans Make in Providing Benefits

Apparently conceding that an indirect economic impact is insufficient to warrant preemption, respondents focus on their contention that the differentials "purposefully discriminate among benefit payors *in order to influence the choices made by ERISA plans*" and maintain that petitioners concede this point. (Travelers Br. at 10, 13, 21-22 and n.11 (emphasis omitted and emphasis added).) This is simply wrong: Influencing ERISA plan choice (as distinct from the choice of any other individual or group regarding the purchase of healthcare coverage) was not the purpose of the differentials.[3] The challenged statutes do not mandate that the 13% differential be passed through to the insurers' customer and be fully reflected in the premiums charged. Rather, the discount

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[3] Travelers inaccurately distinguishes *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993), on the ground that, unlike New York's scheme, the "New Jersey law was [not] designed to influence ERISA plan choice regarding particular forms of health coverage." (Travelers Br. at 22 n.11.) However, in both *United Wire* and this action, plaintiffs challenged differentials in the hospital rate applicable to particular payors, not the underlying DRG rate. *See United Wire*, 995 F.2d at 1189-90. Since not all payors could qualify for the differentials in New Jersey, the allegedly discriminatory impact upon plan choice was precisely the same as in this action.

afforded by the differentials helps offset the higher claims and other costs that the Plans incur by engaging in publicly responsible activities and thus fosters the provision of widespread affordable health insurance. (A-101; JA-188, 153, 165-66.)[4] The differentials simply enable the Plans to charge lower premium rates than would otherwise be possible. The purpose of the differentials is not, as respondents contend, to make the Plans' premiums cheaper than respondents.[5]

Furthermore, respondents' support for the supposed discriminatory effect of the differentials consists solely of the

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[4] Respondents' attack upon the wisdom or effectiveness of the challenged differentials can have no bearing upon the matters before this Court. (*See* Travelers Br. at 6 n.5.) In *Stuart Circle Hospital Corp. v. Aetna Health Management Corp.*, 995 F.2d 500, 504-05 (4th Cir.), *cert. denied*, 114 S. Ct. 579 (1993), in considering whether a state's preferred provider law was saved, the court noted that the "legislative decision to favor an insured's choice of providers does not compel preemption. The wisdom of this decision is a concern of the legislature, not the judiciary." Indeed, in construing the McCarran-Ferguson Act, courts have repeatedly emphasized that it is irrelevant whether a different regulation would have been wiser or would have better served the state's ends. *See Lawyers Title Co. v. St. Paul Title Insurance Corp.*, 526 F.2d 795, 797 (8th Cir. 1975); *Travelers Ins. Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d 80, 83 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973).

[5] Respondents erroneously suggest that except for the differentials, New York's DRG system would be "evenhanded." (Travelers Br. at 2.) By focusing only upon the single component of New York's comprehensive hospital rate-setting and insurance regulatory scheme which they dislike, respondents ignore the numerous factors within the scheme that favor them. Although the differentials favor the Plans, the Plans are disfavored by many other aspects of New York's system. For example, the Plans are subject to investment and other regulatory restrictions not applicable to commercial insurers. Since commercial insurers have greater freedom in investing, they have a greater potential return. And although the HMOs claim that the 9% differential discriminates against them, they are favored as the only payor permitted to negotiate rates. Thus, in evaluating the differentials' alleged discriminatory impact, they must be viewed in the larger context of the regulatory scheme as a whole—not with respondents' tunnel vision.

undisputed fact that most people obtain coverage for hospital services through ERISA plans and self-evident propositions regarding the economic, but not discriminatory, impact of the differentials. Travelers points to the unremarkable facts that the differentials represent 2% to 5% of the cost of providing hospital and medical coverage and that increased costs may result in premium increases. (Travelers Br. at 5.) Correspondingly, the HMOs claim an "increase of up to 3.5% in total costs for most HMOs." (HMOs Br. at 9.)[6] But such differences in costs provide no support for respondents' position. What counts to consumers, including employee benefit plans, is differences in premiums.

However, the Record may be searched in vain for a shred of evidence that the differentials have had an "inexorable effect of tilting ERISA plans away from the disfavored benefit payors and toward the Blues." (Travelers Br. at 16-17.) In fact, the Record reveals that because the Plans provide coverage to the State's poorer risks, the commercial insurers have been able to offer more competitive rates than the Plans, despite payment of the differentials. These more competitive rates have caused the Plans to continue to lose substantial numbers of subscribers from their small group pools. Obviously, without the differential the losses from the Plans' pools would be still greater.[7]

In any event, respondents' discrimination argument cannot withstand analysis. Under respondents' theory, any state law

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[6] This is the entirety of the economic impact in the Record upon which the Second Circuit based its holding that "[t]he surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of healthcare benefits." (JA-53.)

[7] As noted by the State's Insurance Department, for the five-year period from 1983—the year the 13% differential was enacted—to 1987, the Plans lost nearly 200,000 small group subscribers. For the five-year period from 1987 to 1991, Empire alone lost more than 650,000 small group subscribers. (JA-164-67.) "[T]he better risks mov[ed] to commercial insurers who offer lower premiums." (JA-168.)

making one type of coverage more attractive than another would have an impermissible discriminatory impact upon ERISA plans. Since countless state laws impact cost and thus may influence choice, states would be required to leave cost and availability of healthcare primarily to the free market. Apparently, the sole freedom Travelers would allow the legislature is to set a uniform rate for all payors, including Article 43 corporations, commercial insurers, HMOs, self-insured funds, Medicaid, uninsured individuals, etc., provided that it also repeals the multitude of other laws that may impact the costs or choice of providing particular benefits or structuring ERISA plans in a particular fashion.[8]

Here, the challenged differentials do not impermissibly interfere with plan choices and do not require ERISA plans to be structured or administered in a particular way. Nor do they mandate the provision of particular benefits. As such, any potential for indirect economic impact on ERISA plans does not warrant their preemption.

B. Respondents Mischaracterize the Operation and Effect of the Challenged Statutes

Travelers mischaracterizes the 13% differential by stating that it "refers expressly to self-insured ERISA plans." (Travelers Br. at 27.) Although the statute lists self-insured funds

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[8] The Court should also reject respondents' suggestion that it carve out a broad preemption rule for generally applicable state laws in the healthcare arena because this is the realm where ERISA plans typically operate. (Travelers Br. at 17-18; HMOs Br. at 32; Brief of the National Carriers' Conference Committee as *Amicus Curiae* in Support of Respondents ("National Carriers' Br.") at 15; NYSA-ILA Br. at 7-8.) There is no support in either ERISA's legislative history or this Court's decisions for a finding that ERISA plans should be granted special privileges excluding them from complying with any generally applicable state law in areas where they provide benefits. To the contrary, in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), this Court held that ERISA preempted a law that provided favorable treatment to ERISA plans.

as one category of payor, not all self-insured funds are governed by ERISA. And, at the very outset of its analysis, the Second Circuit specifically held that "the challenged statutes do not refer to ERISA plans." (JA-52); *accord United Wire*, 995 F.2d at 1192 n.6 (holding New Jersey's statute is not preempted "simply because it expressly refers to 'self-funded union' plans as one example of a 'third party payor' "). In fact, Travelers concedes that the statute makes no mention of "ERISA plans" or "employee welfare benefit plans." (Travelers Br. at 27.)

The Public Health Law's passing reference to payments made on behalf of "patients . . . enrolled in a self-insured fund," (A-102), is hardly equivalent to the reference to ERISA plans found in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), or *District of Columbia v. Greater Washington Board of Trade*, 113 S. Ct. 580 (1992). In *FMC*, the Pennsylvania antisubrogation statute was preempted because its reference to " '[a]ny program, group contract or other arrangement for payment of benefits' " was part and parcel of a statute requiring ERISA plans to forego subrogation rights. 498 U.S. at 59 (quoting 75 Pa. Cons. Stat. § 1719 (1987)). Similarly, the workers' compensation statute in *Greater Washington Board of Trade* required employers to provide eligible employees with health insurance coverage "measured by reference 'to the existing health insurance coverage' provided by the employer . . . ." 113 S. Ct. at 583 (quoting D.C. Code Ann. § 36-307(a-1)(1) (Supp. 1992)). By contrast, Section 2807-c(1)(b)'s list of payors does not refer to an ERISA plan merely because the term "self-insured fund" is used regardless of its context, and here the context makes clear that the reference is to payors for hospital services.

Apparently recognizing the difference between laws mandating conduct and laws having the potential for only an indirect economic impact on plans, respondents erroneously attempt to transform the differentials into a mandate. (Travelers Br. at 18-19; HMOs Br. at 28-29.) However, contrary to

respondents' assertions, the mandated benefit law at issue in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), was preempted because it was a mandate imposed on ERISA plans—no such mandate on ERISA plans or any other purchasers of hospital services appears here.[9]

Finally, the HMOs' attempt to make themselves synonymous with ERISA plans simply does not do justice to the seriousness of the matters before this Court. Relying upon ERISA's definition of employee welfare benefit plans, the HMOs would conclude that "a law that regulates the means by which an ERISA plan delivers its benefits is self-evidently a law that has a 'connection with' ERISA plans." (HMOs Br. at 20.) However, that ERISA employee welfare benefit plans are defined as plans that provide employee benefits "through insurance or otherwise," 29 U.S.C. § 1002(1), sheds no light whatsoever on the preemption issue. Moreover, if the HMOs are correct, any law regulating insurance companies, self-funded plans or HMOs would "relate to" ERISA plans regardless of how remote or tenuous the relationship to such plan. Similarly unconvincing is the HMOs' argument that because

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[9] The HMOs' reliance upon *Morales v. Trans World Airlines, Inc.*, 112 S. Ct. 2031 (1992), *Wisconsin Department of Industry, Labor and Human Relations v. Gould Inc.*, 475 U.S. 282 (1986), and *Golden State Transit Corp. v. Los Angeles*, 475 U.S. 608 (1986), is similarly unavailing. *Morales* involved the Airline Deregulation Act ("ADA"), which preempts laws "relating to rates, routes or service of any air carrier." 49 U.S.C. § 1305(a)(1) (1988). The Court held that guidelines setting forth the content of air fare advertisements were preempted. First, "every one of the [regulations]. . . [bore] a 'reference to' air fares." *Morales*, 112 S. Ct. at 2039. Second, unlike the challenged differentials, the guidelines had a direct economic effect on air fares. *Gould Inc.* and *Golden State Transit Corp.* similarly addressed statutes mandating or restricting particular conduct.

Interestingly, this Court has found that a state regulation increasing the cost of alcohol from out-of-state sources was not preempted because it "simply raise[d the] price." It did not preclude the military from complying with its obligation to obtain liquor at the most competitive price. *North Dakota v. United States*, 495 U.S. 423, 441 (1990).

they provide healthcare, they are "a surrogate for the ERISA plan." (HMOs Br. at 20.) Were the test providing healthcare, doctors and hospitals would also be "surrogates" for ERISA plans.

C. The Challenged Differentials Do Not Impermissibly Interfere with National Uniformity of Plan Administration

While admitting that hospital costs will vary from hospital to hospital and state to state regardless of whether states regulate rates, Travelers nonetheless contends that states may not alter cost differences so as to "produce *state-created* disuniformity that burdens multi-state plans' attempts to take advantage of the efficiencies of the national market." (Travelers Br. at 23.) Thus, Travelers urges that differences in costs are acceptable so long as those differences are created by market factors alone. Unfortunately, this approach cannot be reconciled with Travelers' position that they are not challenging the DRG system in New York.[10]

In any event, free market conditions will make certain types of coverage more attractive in some states than in others. For example, in some states an employee benefit plan may have a large number of employees in a small area and be able to negotiate favorable hospital rates for its own participants. In other states, the plan may have only a small number of employees and find that it can save the most money by providing coverage through some insurer.

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[10] Although Travelers maintains that it is not challenging New York State's DRG system, *amici* disagree. Recognizing the difficulty of maintaining Travelers' position, *amici* apparently favor a completely free market system. (*See, e.g.*, Brief *Amicus Curiae* for the International Foundation of Employee Benefit Plans in support of Respondents at 12-14; Brief *Amicus Curiae* of the Self-Insurance Institute of America, Inc. in Support of the Respondents at 14.)

D. Congress Did Not Intend to Preempt State Hospital Cost Control and Insurance Regulatory Schemes

Contesting petitioners' position that Congress did not intend to preempt state hospital cost control and insurance regulatory schemes, Travelers relies upon the undisputed fact that Congress intended that preemption be construed broadly. Yet neither Travelers nor *amici* have pointed to anything in ERISA's legislative history specifying an intent to preempt laws such as the challenged differentials. Nor have the HMOs provided any basis for their assertion that Congress determined to leave such matters to the free market.

Respondents also erroneously rely upon the congressional amendment exempting the "Hawaii Prepaid Health Care Act" from ERISA preemption. (*See* Travelers Br. at 30-31; HMOs Br. at 38-39.) But that amendment was enacted specifically in response to a court ruling that Hawaii's *mandatory* employer coverage was preempted. There is no evidence that Congress considered preemption of laws that control hospital costs, regulate insurance and may have a purely indirect economic impact upon choices made by ERISA plans.

Here, affirming the Second Circuit's decision would threaten a wide range of state laws designed to control costs and increase the availability of hospital and medical insurance coverage. (*See* Brief for the States of Minnesota, *et al.* at 16-27 (describing the impact of the Second Circuit's ruling).) Surely, Congress did not intend that ERISA preemption would threaten such drastic ramifications.

II.

NEW YORK'S DIFFERENTIALS ARE SAVED AS INSURANCE REGULATION

In respondents' saving clause argument, the differentials have been somehow transformed from "purposeful interference" with choices of employee benefit plans, solely into regulation of hospital rates. On this score respondents meet themselves coming and going: Respondents simply cannot have it both ways.

And, contrary to respondents' assertion, petitioners do not contend that all laws that "relate to" insurance companies are saved from preemption. Instead, petitioners maintain simply, as this Court's precedents make clear, that the insurance saving clause "save[s] an entire body of law from the sweeping general pre-emption clause." *Metropolitan Life*, 471 U.S. at 746 n.23. In fact, in *Metropolitan Life* this Court refused to construe the saving clause narrowly, finding that it would result in an "unnatural reading of the clause." *Id.*

A. From a Common Sense Perspective the Differentials Regulate Insurance

For decades, New York State's regulation of insurance has been inextricably intertwined with the regulation of hospital rates. Respondents' assertion that the differentials deal only with the payments made by an insurer to the hospital ignores the legislative history, discussions, studies and debates about them that explain how New York seeks to affect the availability and affordability of insurance through the regulation of hospital reimbursement rates. The differentials are not "removed from the contractual relationship" between the policyholder and the insurer—the Record clearly establishes that the differentials are part of the State's plan to promote New Yorkers' access to affordable health insurance.[11] The inno-

[11] Travelers argues that the differentials are not designed to increase access to insurance because they remain in effect even after the

vativeness of the differentials, or as respondents describe them, their "uniqueness" or "unusualness," (*see* Travelers Br. at 3, 35), provides no basis for concluding that such laws do not regulate insurance.[12]

B. Since the Differentials Regulate Insurance as a Matter of Common Sense, Application of the McCarran-Ferguson Act Factors Is Not Warranted

Again, as this Court's precedents establish, this Court "*made use* of the case law interpreting the phrase 'business of insurance' under the McCarran-Ferguson Act" and "[was] *guided*" by such case law. *Pilot Life*, 481 U.S. at 48 (emphasis added). However, the three prong test applied in *Metropolitan Life* and *Pilot Life* was originally developed to determine whether a law was exempt from the antitrust laws because it regulated the "business of insurance." *See Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982); *Group Life Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). The key differences in language between ERISA and the McCarran-Ferguson Act indicate that McCarran's three prong test need not be met in the ERISA context.

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enactment of New York's landmark reform requiring insurers in individual and small group markets to open enroll and community rate. This argument obfuscates the impact of the reform law. (*See* Travelers Br. at 7 n.5.) As previously stated, (Brief for Petitioners New York State Conference of Blue Cross & Blue Shield Plans and Empire Blue Cross and Blue Shield ("Br.") at 9-10 n.8, 38 n.27), under the reform law, no commercial insurer is required to be in the individual or small group health insurance market. Accordingly, most commercial insurers choose not to cover individuals, thus leaving persons with the highest claims cost in the State to be insured by the Plans. (JA-201, 294.) For this reason, the legislature decided to maintain the present differential until the end of 1995.

[12] Contrary to Travelers' assertion, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987), does not support the position that the differentials do not regulate insurance as a matter of common sense. Unlike this action, *Pilot Life* involved a law having its roots in general tort and contract law. Here, the history of the differentials repeatedly underscores their insurance function. (JA-160-68, 216-38.)

As discussed fully in the Plans' principal brief, (Br. at 34-36), *United States Department of the Treasury v. Fabe* broadly applied the three-prong test recognizing that the McCarran-Ferguson Act factors could be applied less rigidly when determining whether a law enacted within the states' traditional police power is exempt from preemption as the business of insurance than when applying the antitrust exemption in 15 U.S.C. § 1012(b). 113 S. Ct. 2202, 2209-10 (1993). Therefore, in the context of the ERISA saving clause, the McCarran-Ferguson factors, which merely provide "guidance" to the Court and are not "necessarily determinative," need not be satisfied. *See Pilot Life*, 481 U.S. at 48; *Union Labor Life Ins. Co.*, 458 U.S. at 129.

C. In Any Event the Differentials Meet the Requirements of the McCarran-Ferguson Act

1. The Differentials Spread Risk

Respondents erroneously attempt to liken the differentials to the private price agreements in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). Here, the Second Circuit correctly held that the differentials spread risk, unlike the private pharmacy agreements in *Royal Drug* which merely allowed the health insurer to reduce its costs for obligations already assumed. (JA-59.) Distinguishing *Royal Drug*, the Second Circuit acknowledged that the differentials' purpose was to encourage healthier persons to participate in the Plans' community pools, and that therefore, the differentials go much further than merely setting a price. (JA-59.)[13]

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[13] Respondents' attempt to distinguish the risk spreading in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), also fails. The differentials, like the mandated benefit law in *Metropolitan Life*, were designed as an insurance law so that "good risk individuals . . . become part of the risk pool" in order to "correct the insurance market." *Id.* at 731.

2. The Differentials Are Integral to the Insurer-Insured Relationship

Travelers concedes that " '[c]ommunity rating and open enrollment'. . . 'play an integral role in the policy relationship between insurer and insured,' " yet argues that the differentials are not integral to that relationship because they "simply increase the prices that hospitals charge patients with certain health coverage, and do not *regulate* community rating and open enrollment . . . ." (Travelers Br. at 40.) However, this ignores the key role that the differentials play in fostering the Plans' ability to provide health insurance to all who seek it, especially those who can not otherwise obtain it. *See supra* note 11. One need only consider the plight of a person who was dropped from coverage by a commercial insurer and was able to obtain coverage from the Plans to determine if such access, stimulated by the differential, is the regulation of insurance. Surely, the differentials are integral to the State's policy of providing broad access to coverage and, therefore, are integral to the relationship between the insured and the insurer.[14]

3. HMOs Are Subject to ERISA's Saving Clause

Under the Second Circuit's ruling, no insurance statute can be saved from ERISA preemption if it applies to HMOs because such a statute would not be considered limited to entities in the insurance industry. However, to the extent HMOs perform insurance functions they are "persons" subject

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[14] Contrary to Travelers' position, *Royal Drug* does not demonstrate that the differentials are not integral to the policy relationship between the insurer and the insured. Unlike the pharmacy agreements in *Royal Drug* (where the contractual arrangement between the pharmacy and the insurer had no connection with the relationship with the insured), the state created the differentials to stimulate practices resulting in insurers providing broad access to coverage for insureds. (Br. at 10-13.)

to laws which "regulate insurance."[15] 29 U.S.C. § 1144(b)(2)(A) (1988).

The HMOs expend great effort informing this Court about how different they are from the Plans and commercial insurers. This is all immaterial to the issue before this Court. Regarding payments for hospital services, HMOs are no different than insurers. HMOs do not provide hospital care: They pay for it just like the Plans and commercial insurers by accepting the risks in providing hospital care and indemnifying their subscribers for such costs in exchange for a premium payment. *See* Br. at 42-43; *see also Ocean State Physicians Health Plan v. Blue Cross & Blue Shield*, 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990); Philip S. Neal & Suzanne M. Papiewski, *Taxation of HMOs Now and Under Health Care Reform—Separating Fact from Fiction*, Exempt Organization Tax Review, Vol. 9, No. 3 (March 1994). And as noted in the Plans' brief, (Br. at 44-46), many courts have correctly found that HMOs perform an insurance function when they accept premium payments in exchange for healthcare services because the HMOs remain at risk.[16] Significantly, from a national perspective, *amici* The National Governors' Association and The National Association of Insurance Commissioners agree that HMOs engage in

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[15] Contrary to the HMOs' contention, HMOs are not subject to insurance regulation only as determined by the Department of Health. (HMOs Br. at 46.) Rather, HMOs are subject to specific insurance regulations in accordance with the provisions of N.Y. Ins. Law § 1109(a) as well the Public Health Law. (*See* Br. at 42-44.)

[16] Respondents' citation to the more than 50 year-old case of *Jordan v. Group Health*, 107 F.2d 239 (D.C. Cir. 1939), does not change this result. In *Jordan*, no risk was transferred to the HMO: It merely had to use its best efforts to arrange for care. The only other circuit court case cited by respondents, *O'Reilly v. Ceuleers*, 912 F.2d 1383 (11th Cir. 1990), is equally inapplicable. *O'Reilly* concerned an HMO in its role as the fiduciary of its own employee benefit plan and did not address whether a law applicable to the HMO was saved as insurance regulation.

the primary insurance function ("assumption of third party's risk in return for a fixed payment") and that HMOs are not clearly distinct from insurers because many insurers "provide coverage through managed care arrangements which deliver services through provider networks, as do HMOs." (Brief for National Governors' Association *et al.* as *Amici Curiae* in Support of Petitioners at 12-13 n.7.) The bottom line is that HMOs and insurers perform the same functions for individuals paying premiums—they accept the risk of providing healthcare services.

The HMOs' reliance on the provisions of the Health Maintenance Organizations Act of 1973 is likewise misplaced. Through the HMO Act, Congress sought to provide "strong federal commitment to the growth and development of [HMOs]" and, accordingly, restricted specific types of state laws which it deemed might stifle that growth. S. Rep. No. 129, 93d Cong., 1st Sess. (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033, 3057. Thus, 42 U.S.C. § 300e-10 exempts HMOs from state insurance laws "respecting initial capitalization and establishment of financial reserves against insolvency". However, although it could have done so, Congress did not preempt the application of all insurance laws as to HMOs. In fact, since the HMO Act restricts *only* insurance laws relating to capital and insolvency, Congress was obviously aware that insurance statutes were applicable to HMOs.[17]

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[17] Finally, ERISA's definition of employee benefit plan, 29 U.S.C. § 1002(1), which allows plans to provide benefits "through insurance or otherwise," provides no support for the HMOs' claim that the saving clause does not include laws regulating HMOs within its reach. The "or otherwise" language refers to self-insured plans, but even if it referred to HMOs, this has no bearing upon whether laws that apply to HMOs and insurers can be saved as insurance regulation.

D. The Deemer Clause Is Not Applicable

Nor does ERISA's deemer clause operate to preempt the challenged differentials as to self-insured plans.[18] The "deemer" clause provides:

> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies or investment companies.

29 U.S.C. § 1144(b)(2)(B) (1988).

New York's hospital reimbursement and insurance regulatory scheme regulates the hospital rates of all categories of payors. *See* N.Y. Pub. Health Law § 2807-c(1) (McKinney 1993). Indeed, to be effective as a coherent, integrated system, it must encompass all payors, "not just insurance companies." (JA-276.) Yet from this it does not follow that the statute "purports" to regulate self-insured funds as "insurance companies" as required by the deemer clause. Rather than "deeming" the self-insured funds to be insurers for regulatory

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[18] The Second Circuit neither addressed the applicability of the deemer clause nor specifically discussed preemption of the differentials as to self-insured plans. However, the Plans and Empire acknowledge that respondents and *amici* correctly state that the district court's ruling encompassed self-funded plans. In resolving a controversy involving the scope of the district court's stay pending appeal, Judge Freeh ruled that while the appeal was pending, "the named parties to this action, including Travelers, in its capacity as claims fiduciary of the Railroad Plans [a self-funded plan], are directed to pay the 13% differential with respect to all hospital claims . . . ." (*See* Appendix to National Carriers' Br. at 30a.) Thus, in fashioning his stay order, Judge Freeh took pains to treat self-insured plans exactly as he did commercial insurers. As the Record makes clear, the issue of the applicability of the deemer clause is properly before this Court.

purposes, the challenged statute treats self-insured funds as payors of hospital charges. As such, the deemer clause does not come into play.

The statute at issue here is also distinguishable from that at issue in *FMC Corp. v Holliday*, 498 U.S. 52 (1990), where this Court held that a Pennsylvania anti-subrogation law was preempted as it applied to self-insured plans even though it was saved as to insured plans. Pennsylvania's anti-subrogation law directly prohibited the self-insured plan from recovering the benefits it had paid to plan participants out of their tort recovery. In other words, the statute prohibited the plan from acting in accordance with its explicit provisions. In that respect, the anti-subrogation law in *FMC* is identical to the mandated benefit law upheld with respect to insurers but not self-insured funds in *Metropolitan Life*.

By contrast, the challenged statutes control the rates of payors for hospital services; they neither require self-funded plans to do anything nor prohibit them from doing anything. In fact, the statutes actually offer an *option* to self-insured plans: They may pay covered hospital costs by either remitting the DRG rate plus the 13% differential paid by essentially every other payor category in New York directly to the hospitals, they may purchase services through the Plans or they may opt out of the DRG system entirely by remitting the hospital's charges to the employee or patient. *See* N.Y. Pub Health Law §§ 2807-c(1)(a)-(c) (McKinney 1993). This choice allows self-insured plans to benefit from participation in New York's hospital cost control law, but does not require them to pay the 13% differential. Therefore, unlike *FMC*, whether or not a self-insured plan pays the 13% differential is wholly a matter of choice. Because the differential statute at bar does not impose any regulatory mandates upon self-funded plans but rather treats them as payors for hospital services, the deemer clause does not operate to preempt any portion of the laws at issue.

CONCLUSION

For all of the foregoing reasons, and for all the reasons stated in the Brief for Petitioners New York State Conference of Blue Cross & Blue Shield Plans and Empire Blue Cross and Blue Shield, the decision of the Second Circuit Court of Appeals that ERISA preempts New York's statutorily prescribed differentials should be reversed.

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Respectfully submitted,

BARTLEY J. COSTELLO, III
EILEEN M. CONSIDINE
BEVERLY COHEN
HINMAN, STRAUB, PIGORS & MANNING, P.C.
Attorneys for New York State Conference of Blue Cross & Blue Shield Plans
121 State Street
Albany, New York 12207
(518) 436-0751

ROBERT A. BICKS
(*Counsel of Record*)
PATRICIA ANNE KUHN
ANTHONY C. KAYE
WHITMAN BREED ABBOTT & MORGAN
Attorneys for Empire Blue Cross and Blue Shield
200 Park Avenue
New York, New York 10166
(212) 351-3000

ALAN C. DREWSEN
Senior Vice President and General Counsel
JEFFREY D. CHANSLER
Vice President and Associate General Counsel
EMPIRE BLUE CROSS AND BLUE SHIELD
622 Third Avenue
New York, New York 10017
(212) 476-3200